



NTSB National Transportation Safety Board

**Improved Human and
Organizational
Performance Through
Collaboration:
*Lessons Learned in
Transportation***

Presentation to:

Human and Operational
Performance Conference

Name: Christopher A. Hart

Date: September 18, 2013

The Contrast

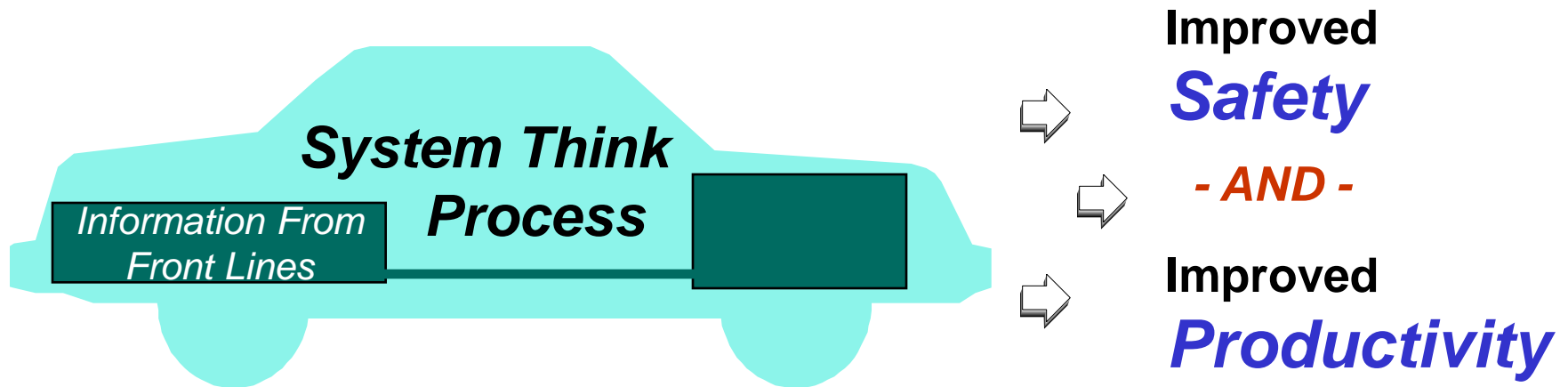
- **Conventional Wisdom:**

Improvements that reduce risk usually
also reduce productivity

- **Lesson Learned from Proactive
Aviation Safety Information Programs:**

Risk can be reduced in a collaborative way that also
results in *immediate productivity improvements*

Process Plus Fuel Creates A Win-Win



Outline

- **The Context**
- **Importance of “System Think”**
- **Importance of Better Information**
- **Safety Benefits**
- **Productivity Benefits**
- **Roles of Leadership and Regulator**

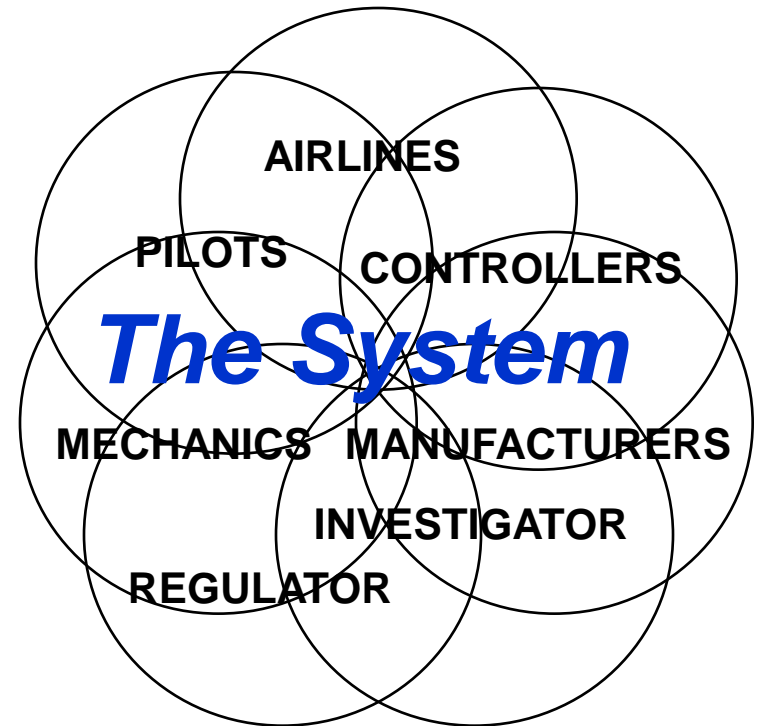
NTSB 101

- Independent federal agency, investigate transportation mishaps, all modes
- Determine probable cause(s) and make recommendations to prevent recurrences
- Primary product: Safety recommendations
 - Favorable response > 80%
- ***SINGLE FOCUS IS SAFETY***
- Independence
 - Political: Findings and recommendations based upon evidence rather than politics
 - Functional: No “dog in the fight”



The Context: Increasing Complexity

- **More System**
Interdependencies
 - Large, complex, interactive system
 - Often tightly coupled
 - Hi-tech components
 - Continuous innovation
 - Ongoing evolution
- **Safety Issues Are More Likely to Involve**
Interactions Between Parts of the System



Effects of Increasing Complexity:

More “Human Error” Because

- **System More Likely to be Error Prone**
- **Operators More Likely to Encounter Unanticipated Situations**
- **Operators More Likely to Encounter Situations in Which “By the Book” May Not Be Optimal (“workarounds”)**

The Result:

Front-Line Staff Who Are

- **Highly Trained**
- **Competent**
- **Experienced,**
- **Trying to Do the Right Thing, and**
- **Proud of Doing It Well**

. . . Yet They Still Commit

**Inadvertent
Human Errors**

The Solution: System Think

***Understanding how a
change in one subsystem
of a complex system may
affect other subsystems
within that system***

“System Think” via Collaboration

Bringing all parts of a complex system together to collaboratively

- **Identify potential issues**
- ***PRIORITIZE* the issues**
- **Develop solutions for the prioritized issues**
- **Evaluate whether the solutions are**
 - **Accomplishing the desired result, and**
 - **Not creating unintended consequences**

When Things Go Wrong

How It Is Now . . .

You are highly trained

and

If you did as trained, you
would not make mistakes

so

You weren't careful
enough

so

You should be **PUNISHED!**

How It Should Be . . .

You are human

and

Humans make mistakes

so

Let's *also* explore why the
system allowed, or failed to
accommodate, your mistake

and

Let's **IMPROVE THE SYSTEM!**

Fix the Person or the System?

Is the **Person**
Clumsy?

Or Is the
Problem . . .

The **Step???**



Enhance Understanding of Person/System Interactions By:

- Collecting,**
 - Analyzing, and**
 - Sharing**
- # **Information**

Objectives:

Make the System

***(a) Less
Error Prone***

and

***(b) More
Error Tolerant***

The Health Care Industry

To Err Is Human:

Building a Safer Health System

“The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system.”

Institute of Medicine, Committee on Quality of Health Care in America, 1999

Major Source of Information: Hands-On “Front-Line” Employees

**“We Knew About
That Problem”**

***(and we knew it might hurt
someone sooner or later)***



Next Challenge



Legal/Cultural Issues

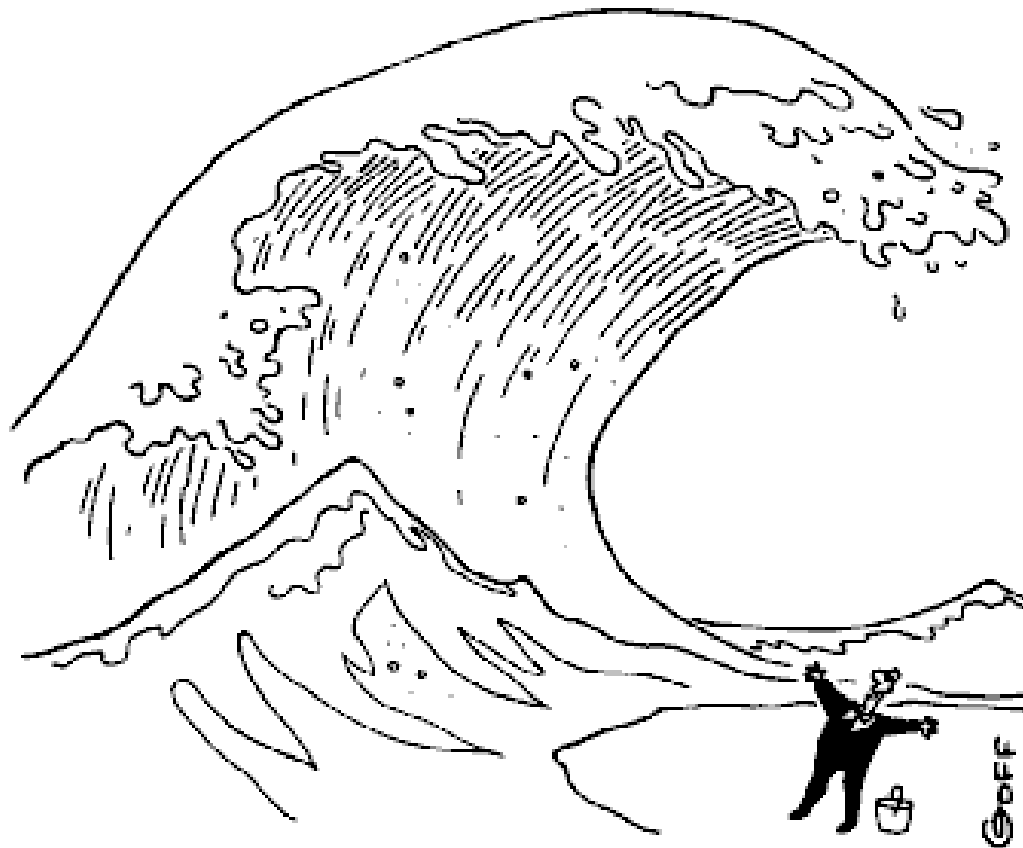
Improved Analytical Tools

As we begin to get over the first hurdle, we must start working on the next one . . .



Information Overload

© 1996 Ted Goff



"EUREKA! MORE INFORMATION!"

From Data to Information

Tools and processes to convert large quantities of data into useful information

Data Sources

Info from front line staff and other sources

DATA



Analysts

USEFUL

INFORMATION

Smart Decisions

- Identify issues
- **PRIORITIZE!!!**
- Develop solutions
- Evaluate interventions

Tools

Processes



Aviation Success Story

65% Decrease in Fatal Accident Rate,
1997 - 2007

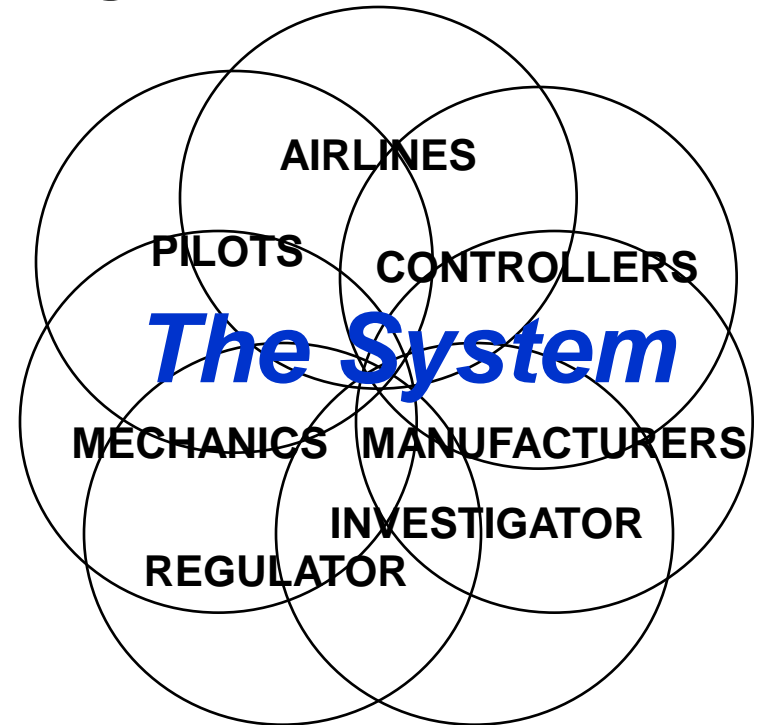
largely because of
System Think

fueled by
***Proactive Safety
Information Programs***

P.S. Aviation was already considered **VERY SAFE** in 1997!!

Aviation “System Think” Process

- Engage All Participants In Identifying Problems and Developing and Evaluating Remedies
- Airlines
- Manufacturers
 - *With the systemwide effort*
 - *With their own end users*
- Air Traffic Organizations
- Labor
 - *Pilots*
 - *Mechanics*
 - *Air traffic controllers*
- Regulator(s) [Query: Investigator(s)?]



Moral of the Story

Anyone who is
involved in the *problem*
should be
involved in the *solution*

Collaboration: A Major Paradigm Shift

- **Old: Regulator identifies a problem and proposes solutions**
 - Industry skeptical of regulator's understanding of the problem
 - Industry resists regulator's solutions and/or implements them begrudgingly

- **New: Collaborative “System Think”**
 - Industry involved in identifying problem
 - Industry “buy-in” re interventions because everyone had input, everyone's interests considered
 - Prompt and willing implementation
 - Interventions evaluated . . . *and tweaked as needed*
 - Solutions probably more effective and efficient
 - Unintended consequences much less likely



Challenges of Collaboration

- Human nature: “I’m doing great . . . *the problem is everyone else*”
- Differing and sometimes competing interests
 - Labor-management issues
 - May be potential co-defendants
- Regulator probably not welcome
- Not a democracy
 - Regulator must regulate
- Requires all to be willing, in their *enlightened self-interest*, to leave their “comfort zone” and think of the System



Manufacturer Level “System Think”

Aircraft manufacturers are increasingly seeking input, from the earliest phases of the design process, from

- *Pilots* (User Friendly)
- *Mechanics* (Maintenance Friendly)
- *Air Traffic Services* (System Friendly)

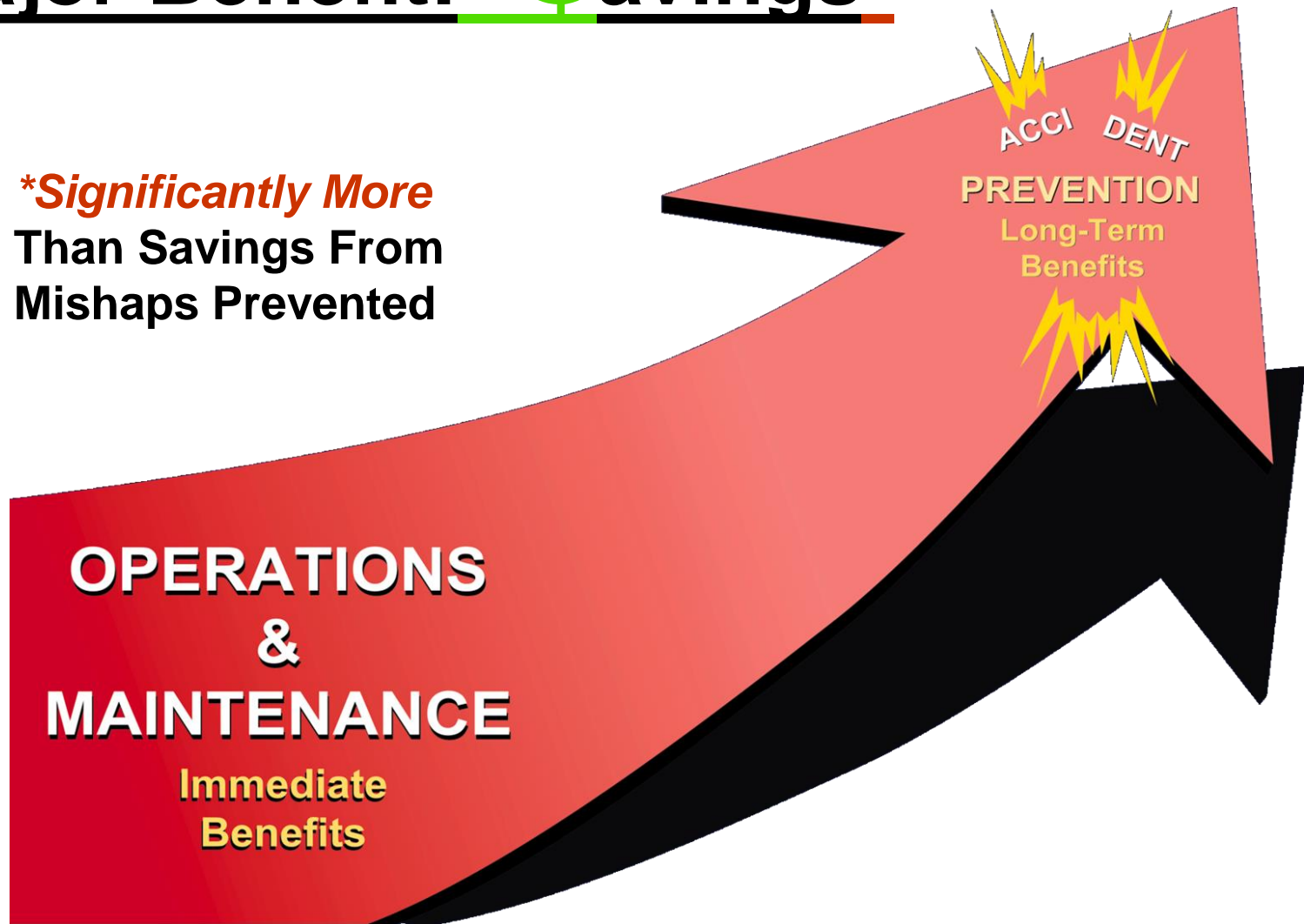
System Think at Other Levels

- **“System Think” can be successful at any macro/micro level, including**
 - Entire industry
 - Company (some or all)
 - Type of activity
 - Facility
 - Team
- **Persistent workplace problem?**



Major Benefit: \$avings*

**Significantly More*
Than Savings From
Mishaps Prevented



Not Only Improved Safety, But Improved Productivity, Too

- **Ground Proximity Warning System**
 - *S: Reduced warning system complacency*
 - *P: Reduced unnecessary missed approaches, saved workload, time, and fuel*
- **Flap Overspeed**
 - *S: No more potentially compromised airplanes*
 - *P: Significantly reduced need to take airplanes off line for **VERY EXPENSIVE (!!) disassembly, inspection, repair, and reassembly***



But Then . . .

Why Are We

So Jaded in The Belief That

Improving Safety

Will Probably

Hurt The Bottom Line??



Costly Result\$ Of Safety Improvements Poorly Done

Safety *Poorly* Done

1. Punish/re-train operator

- *Poor workforce morale*
- *Poor labor-management relations*
- *Labor reluctant to tell management what's wrong*
- *Retraining/learning curve of new employee if “perpetrator” moved/fired*
- *Adverse impacts of equipment design ignored, problem may recur because manufacturers are not involved in improvement process*
- *Adverse impacts of procedures ignored, problem may recur because procedure originators (management and/or regulator) are not involved in improvement process*

Safety *Well* Done

Look beyond operator,
also consider system
issues



Costly Result\$

Of Safety Poorly Done (con't)

Safety **Poorly** Done

2. Management decides remedies unilaterally

- *Problem may not be fixed*
- *Remedy may not be most effective, may generate other problems*
- *Remedy may not be most cost effective, may reduce productivity*
- *Reluctance to develop/implement remedies due to past remedy failures*
- *Remedies less likely to address multiple problems*

3. Remedies based upon instinct, gut feeling

- *Same costly results as No. 2, above*

Safety **Well** Done

Apply “System Think,” *with workers*, to identify and solve problems

Remedies based upon evidence (including info from front-line workers)

Costly Result\$

Of Safety Poorly Done (con't)

Safety **Poorly** Done

4. Implementation is last step

- *No measure of how well remedy worked (until next mishap)*
- *No measure of unintended consequences (until something else goes wrong)*

Safety **Well** Done

Evaluation after implementation

Query: Is Safety Good Business?

- *Safety implemented poorly can be **very costly (and ineffective)***
- *Safety implemented well, in addition to improving safety more effectively, can also **create benefits greater than the costs***

The Role of Leadership

- Demonstrate Safety Commitment . . .

But Acknowledge That Mistakes Will Happen

- Include “Us” (e.g., System) Issues,

Not Just “You” (e.g., Training) Issues

- **Make Safety a Middle Management Metric**

- Engage Labor Early

- Include the **System** --

Manufacturers, Operators, Regulator(s), and Others

- Encourage and Facilitate Reporting

- Provide **Feedback**

- Provide Adequate **Resources**

- **Follow Through** With Action



How The Regulator Can Help

- Emphasize the importance of System issues *in addition to (not instead of)* worker issues
- Encourage and participate in industry-wide “System Think”
- Facilitate collection and analysis of information
 - Clarify and announce *policies for protecting information and those who provide it*
 - Encourage other industry participants to do the same
- Recognize that *compliance* is very important, but the *mission is reducing systemic risk*

Thank You!!!



Questions?